Report to the Legislature Pursuant to AB 2394, Chapter 802, Statutes of 2000

Feasibility of a Establishing a Pilot Program that Would Allow Mexican and Caribbean Licensed Physicians and Dentists to Practice in Nonprofit Community Health Centers In California's Medically Underserved Areas

Chair of the Subcommittee:

Diana M. Bontá, R.N., Dr. P.H., Department of Health Services Director

PILOT PROJECT ELEMENT MATRIX

AB 2394 Pilot Project Element Matrix

Assembly Bill (AB) 2394 (Firebaugh, Chapter 802, Statutes of 2000) created the Subcommittee of the Task Force on Culturally and Linguistically Competent Physicians and Dentists (Subcommittee). AB 2394 charged the Subcommittee with examining the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas.

The attached matrix summarizes possible short-, mid-, and long-term elements of a pilot project to increase the number of culturally and linguistically competent physicians and dentists. The matrix reflects elements that were included in written proposals submitted by Subcommittee members to the Subcommittee at its June 19, 2001, and July 10, 2001 meetings. The reader should refer to the attached written proposals for more details on any given element and also for other background issues and areas of concern.

The various proposals have five major areas of difference. These five are:

1. The temporary versus permanent nature of a project
2. The placement of project participants
3. The means for assuring cultural and linguistic competency of participants
4. The time to implement the project (short-term, one-two years vs. longer term)
5. Licensing and professional residency requirements for participants

Three elements drawn from various proposals are existing programs that require a brief explanation, which was not provided in any of the written proposals. These three programs are:

1. The Fifth Pathway Program;
2. The California Code of Regulations Title 16, Section 1324 Program; and
3. The California Shortage Area Medical Matching Program.

A brief description of these programs follows.

<u>The Fifth Pathway Program</u> (Information provided by the Council on Medical Education, American Medical Association, posted at the International Medical Graduate Institute web site at www.imgi.org/fifthpathway1.html)

"Many foreign medical schools require students to participate in an internship or to fulfill social service obligations after the completion of the didactic portion of their education before the M.D. degree can be awarded. The Fifth Pathway Program was developed by the Council on Medical Education of the American Medical Association (AMA) to expedite the return of citizens who are studying medicine abroad to the United States. Under this program, students who have completed the academic curriculum at a foreign medical school may substitute a year of supervised clinical training at a U.S. medical school for the internship or social service obligation required by the foreign medical

school. The clinical training offered by participating U.S. medical schools is comparable to the clinical or junior internship offered to students in the United States during the fourth year of medical school. After the successful completion of these clinical studies, Fifth Pathway participants may enroll in a graduate medical training program without receiving a formal degree from the foreign medical school. Students may enroll in a graduate medical program by participating in the National Resident Matching Program (NRMP) or through individual negotiations with a particular residency program.

To be eligible for the program, U.S. citizens must meet the following prerequisites:

Completion of undergraduate premedical work at an accredited U.S. college, the quality of which must be acceptable for matriculation at a U.S. medical school.

Matriculation at a medical school outside the United States, Puerto Rico, or Canada, which is listed in the World Directory of Medical Schools published by the World Health Organization.

Completion of all formal requirements of the foreign medical school except the internship and/or social service obligation.

Achievement of scores satisfactory to the sponsoring medical school on a screening examination, preferably administered nationally and acceptable to the Council on Medical Education. The student's academic records and skills will be evaluated by the faculty to identify any deficiencies to be addressed by the supervised clinical program. The Council on Medical Education has urged all state boards of medical examiners to consider successful participants in the Fifth Pathway Program for licensure on the same basis they now consider foreign medical graduates with ECFMG certification. However, not all states recognize Fifth Pathway participants as eligible candidates for licensure. Program participants should be aware that the M.D. degree is often a prerequisite for licensure in many states."

According to Ron Joseph, Executive Director, Medical Board of California, there are currently no medical schools in California that participate in this program. The University of California, Irvine participated in the program in the past. "Revitalizing" the Fifth Pathway program in California would require recruiting a California medical school to participate in the program.

The California Code of Regulations Title 16, Section 1324 Program

California Code of Regulations Title 16, Section 1324 (repealed in 1997) allowed foreign medical graduates to complete the postgraduate training required for California licensure in either a standard residency program approved by the Accreditation Council on Graduate Medical Education or in a healthy facility approved by the Medical Board. A copy Section 1324 is attached (Attachment A).

The California Shortage Area Medical Matching Program (CAL-SAMMP)

The CAL SAMMP Program identifies and works with minority and other medical residents and physician assistant (PA)/nurse practitioner (NP) students and other young

providers to inform them of practice options in the minority shortage area(s) of California in which they want to practice when they complete their training. CAL SAMMP then works to match individuals with positions at shortage area sites and practices. CAL SAMMP has matched over 115 primary care physicians and PAs/NPs to shortage area clinics and practices throughout the State. CAL SAMMP is funded by the Federal Office of Minority Health (OMH).

AB 2394 Pilot Project Element Matrix

Short-Term[1] Elements of a Pilot Project to Increase the Number of Culturally and Linguistically Competent Physicians and Dentists

	Residency Status	Licensure Status	English Proficiency Demonstrated	Pass UMLE Part I	Pass USMLE Part II	Pass USMLE Part III	Pass National Dental Exam	Develop Licensing Exam In Spanish	Serve U.S. Residency	Streamline/ Facilitate Application Process	Establish Academic Reciprocity with Foreign Schools	Integrate U.S. IMGs	Allied Health Professions Training/Welcome Home Program	Scholarships	Loan Forgiveness	Practice Location
California Dental Association		Temporary					X		1 year internship in extramural facility affiliated with a dental school		X				X	
Dental Board of California	Temporary	Temporary					X				X				X	Pilot clinics
California Medical Association	Temporary		X	X	X	X		X	24 months for IMGs (12 months if pass SPEX[2] exam)	X					X	Pilot clinics
Medical Board of California			X	X	X	X				X	X	X				
California Hispanic Health Care Association	Temporary – 3 years	Temporary – 3 years	Enroll in English instruction after achieving licensure and placement		X	X	X	X	6 month, UC-sponsored, plus 6 month externship at place of employment (doctor) 6 month externship at place of employment, dental-school sponsored (dentist)		X	X	X			Non-profit community health centers in 18 specified counties
California Latino Medical Association	Permanent		X	X	X	X					X	X	X	X	X	Free and community clinics throughout the State
Latino Coalition for a Healthy California	Permanent	Permanent	X	X	X	X	X	X	24 months for IMGs (12 months if pass SPEX[2] exam)	X	X	X	X	X	X	Free and community clinics throughout the State

[1]Short-term elements are those that may take 1-3 years to completely implement.
[2]SPEX – Special Purpose Examination. A clinical competency exam required of some U.S. and international graduates in varying situations, and for applicants whose initial written exam scores are determined to be more than 10 years old.
IMG – International Medical Graduate
UC – University of California

AB 2394 Pilot Project Element Matrix

Mid-Term[1] and Long-Term[2] Elements of a Pilot Project to Increase the Number of Culturally and Linguistically Competent Physicians and Dentists

Mid-Term[1]								Long-Term[2]			
	Create New Residency Slots	**Reinstitute Fifth Pathway**	**Reinstitute CCR Title 16 Section 1324 Program**	**Expand Existing GME Programs that Focus on Underserved Areas**	**Expand CA Shortage Area Medical Matching Program**	**Study/Improve Clinic Recruitment**			**Increase U.S. Minority Health Professions Applicant Pool**	**Ensure Health Professions Education Incorporates Cultural and Linguistic Competency**	**Require Cultural and Linguistic Competency as Elements of Licensure and CME**
California Dental Association								**California Dental Association**			
Dental Board of California						X		**Dental Board of California**			Dental continuing education renewal credit
California Medical Association	In pilot project clinics and underserved areas					X		**California Medical Association**			
Medical Board of California	X	X		X		X		**Medical Board of California**			
California Hispanic Health Care Association	X							**California Hispanic Health Care Association**			
California Latino Medical Association		X	X	X	X			**California Latino Medical Association**	X	X	X
Latino Coalition for a Healthy California	In pilot project clinics and underserved areas	X	X	X	X	X		**Latino Coalition for a Healthy California**	X	X	X

[1]Mid-term elements are those that may take 3-5 years to completely implement.
[2]Long-term elements are those that may take 5 or more years to completely implement
CCR – California Code of Regulations
CME – Continuing medical education

§ 1324. Postgraduate Training.

(a) The postgraduate training required in Section 2101, 2102 and 2103 of the code for graduates of foreign medical schools may be obtained in either:

(1) A health facility approved pursuant to Section 1321 above ("ACGME programs"), or

(2) A health facility accredited by the Joint Commission on the Accreditation of Healthcare Organizations and by the division, which meets the criteria set forth in Section 1325.5, subsection (a), except that such a health facility shall have a minimum capacity of 100 beds and staff teachers may be board-eligible or have equivalent training and experience ("Section 1324 programs").

(b) Postgraduate training may be in a categorical or flexible training program; however, it shall include minimum of four (4) months training in the area of general medicine.

(c) Section 1324 Programs. If the postgraduate training program is obtained in a health facility approved under subsection (a)(2), all the following shall apply:

(1) The postgraduate training program shall be approved under this section by the division before it is commenced by the trainee.

(2) If the health facility is the site of any subscribed residency programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the division shall require, on a case by case basis, that the trainee will receive adequate supervision and training.

(3) The health facility shall meet all of the following requirements:

(A) Accept responsibility for the medical education and training of trainees in the program and for the health services provided by them.

(B) Have a governing body, administration, management, medical director, and teaching staff necessary to administer the educational needs of the program.

(C) Accept the responsibility for the quality of the program and insure that all persons involved with the program properly discharge their obligations to it.

(D) Appoint a medical director for the program who is board certified in a specialty area of medicine.

(E) Provide errors and omissions coverage (professional liability insurance) for all trainees in the program

(F) A maximum of $6,000 per year may be charged each trainee to reimburse the program or health facility for administrative and other costs actually incurred in the training of the trainee.

(G) A stipend may be paid to each trainee in the program.

(4) The medical director of the program shall meet all of the following requirements:

(A) Develop and formalize in writing the general objectives of medical education and the educational goals of the program.

(B) Develop a core curriculum to accomplish the educational goals.

(C) Annually review the institutional plans for the educational program.

(D) If outside facilities and staff are used to supplement the program, the approved facility's medical director shall be responsible for the quality of education at the supplemental facilities.

(E) Develop criteria for the selection of trainees into the program and for the selection of teaching staff.

(F) Develop methods for evaluating, on a regular basis not less than monthly, the effectiveness of the program and the competency of the trainees. The evaluation shall include input from the trainees who shall be required to document their experiences in writing.

(G) Develop criteria for the dismissal of trainees whose performance is not satisfactory.

(H) Procedural due process shall be provided in the dismissal of any trainees from the program.

(5) All trainees shall have the following responsibilities when participating in a program:

(A) Provide safe, effective, and compassionate patient care in the program under supervision which is commensurate with the level of the trainee's advancement and responsibility.

(B) Participate fully in the educational activities of the program, as required.

(C) Participate in institutional programs and activities involving the medical staff, and adhere to established practices, procedures, and policies of the facility.

(D) Develop a personal program of self-study and professional growth with guidance from the teaching staff.

(E) At the request of the medical director, participate in institutional committees and councils.

(6) A training agreement shall be executed with each trainee accepted into the program. The agreement shall include all of the following:

(A) The responsibilities of the parties as set forth in this regulation.

(B) The length of the training program.

(C) The usual call schedule of assignments.

(D) As agreed upon between the parties, financial support, benefits, vacation, professional and sick leave, professional liability insurance, health insurance, other insurance coverage for the trainee and his or her spouse and dependents, living quarters or subsidy, meals, and laundry.

(E) Practice privileges and other professional activities which may be permitted or required outside the program.

(F) The guarantee of procedural dues process for dismissal from the program.

(G) Assurance that if the program is satisfactorily completed, the issuance of a certificate of completion shall not be conditioned upon the payment of any fees to the facility or the program.

(7) The certificate of completion of the Section 1324 program submitted by the medical director shall include an evaluation of the performance of the trainee in the training program which is submitted to the division at the completion of the training program.

Note. Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2005, 2102, 2102 and 2103, Business and Professions Code.

History

1. Amendment filed 8-15-78; effective thirtieth day thereafter (Register 78, No. 33).
2. Amendment of subsection (a) filed 8-5-81; effective thirtieth day thereafter (Register 81, No. 32).
3. Amendment of subsection (a) filed 9-21-83; effective thirtieth day thereafter (Register 83, No. 39)
4. Amendment filed 11-1-84; effective thirtieth day thereafter (Register 84, No. 47).
5. Amendment of heading and subsections (a)-(c) filed 10-12-89; operative 11-11-89 (Register 89, No. 42).
6. Amendment filed 5-6-92. operative 6-5-92, Register 92, No. 19).

PROPOSALS RECEIVED BY THE SUBCOMMITTEE

INDEX

CALIFORNIA DENTAL ASSOCIATION
Government Relations Office

June 18, 2001

Members
Subcommittee of the Task Force on Culturallly and
Linguistically Competent Physicians and Dentists

The California Dental Association is a member of this subcommittee, and we welcome the opportunity to provide input with regard to the May 1, 2001 version of AB 1045 (Firebaugh).

CDA.

The comments and concerns expressed here are limited to those aspects of the bill that we believe we are in a position of authority to discuss.

We have approached our comments with a couple of thoughts foremost. First, any pilot program must ensure the integrity of the dental licensure process and provide adequate safeguards to assure patient safety and quality care. Second, any pilot project by its nature must strive to provide an innovative approach. We believe the following recommendations accomplish both of those objectives.

1. Dentists must pass the National Dental Board Examinations, parts 1 and II given by the Joint Commission on National Dental Examinations. Part I consists of fours examinations covering the basic biomedical sciences and dental anatomy. Dental students in the United States take this portion of the board at the end of the sophomore year. Part II consists of one comprehensive examination covering clinical dental subjects, pharmacology, behavioral science and dental public health. Because of their complementary nature, part I must be taken and passed before part II is attempted. A certificate is only awarded after both parts are passed. These exams were designed to determine basic science knowledge as well as diagnostic and treatment planning skills.

2. After successful completion of the National Boards, the Dental Board of California would then issue a permit to the dentists to practice under the following parameters:

   a. a one-year internship in a clinic certified as an extramural facility. An extramural facility is defined as a clinic, formally affiliated with a dental school, which has a volunteer faculty member(s) who have been calibrated and standardized by the affiliating dental school to ensure that educational requirements are consistent and that quality assurance is maintained.

   b. at the end of the one-year internship, the dentist would receive a formal assessment and approval by the supervising clinician to ensure that the candidate may practice unsupervised in the clinics currently defined in this bill, for the time period specified in this bill. It is during this phase that an individual's clinical skills are assessed.

There are other more problematic issues that directly affect the outcome and success of this legislation, and although CDA has commented on what is acceptable to us, we cannot speak for the organizations and agencies whose participation is essential to this bill, such as the Joint Commission on National Dental Examination, the Dental Board of California, and the five California dental schools. These entities would be responsible for many of the processes discussed herein and should be given the opportunity to provide their perspective about what might be required both logistically and financially in order to make this proposal truly feasible.

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Although this letter focuses on attempting to address the issue specifically presented in AB 1045 which is being viewed as an immediate solution, CDA believes that a number of approaches exist that may help alleviate access difficulties.

Full implementation of AB 1116 (Keeley), which was signed in 1997. This proposal provides the authority for the Dental Board to approve foreign dental schools. The regulations implementing this process are currently under review by the Department of Consumer Affairs. Already, three dental schools in Mexico have expressed an interest in the approval process. The approval process coupled with an aggressive recruitment and promotional campaign could encourage many dentists to come to California and practice in clinics aimed at serving the Latino community. Focus on this type of approach would keep the current licensure system in place but assure culturally and linguistically competent and sensitive dentists.

Additionally, loan forgiveness programs such as AB 668 (Chan) should be aggressively encouraged and funded. This proposal would have created a program using minimal general funds, as well as private funds to provide for repayment of student loans for dentists willing to provide a minimum of two years of dental care in an underserved community. With the average debt ranging between $80,000 and $120,000, dentists have little choice but to begin practice in an area where a greater income is guaranteed. Because of 2001-02 budgetary constraints, this bill will now only study the problem instead of attempting to provide immediate relief.

CDA continues to believe that it is important to provide dental care to California's residents who lack access to dental care, and will continue to work toward that end.

Sincerely,

Jack Broussard, D.D.S.
President

California Medical Association

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Physicians dedicated to the health of Californians

CORRECTED VERSION

To: Subcommittee of the Task Force on Culturally and Linguistically Competent Physicians and Dentists

From: The California Medical Association

Date: June 11, 2001

Re: Recommendations for the Proposed Pilot Project

The California Medical Association strongly supports equal access to care for California's diverse population and is especially concerned about care for the uninsured and those living in underserved areas. We are committed to working toward effective and appropriate means to increase access to care. In furtherance of that goal, we offer the following recommendations to the Subcommittee:

Short Term

1. The process of application for licensure by the pilot physicians should be streamlined by the Medical Board of California, which should act as a facilitator for licensing these physicians.

2. Pilot project physicians should take the same qualifying exams (USMLE 1, 2, and 3) as required of other international medical graduates (IMGs), however USMLE 1 could be taken in Spanish as long as the applicant passes an English proficiency exam.

3. Pilot project physicians should fulfill the same Residency Requirements as other IMGs, and California medical schools should be encouraged to establish a supervised residency training program in the pilot clinics to allow pilot physicians to meet residency training requirements while treating patients in those clinics.

4. The term of service for pilot physicians should be defined.

Long Term

1. California medical schools' residency programs should be established in underserved areas to increase the workforce in those areas and to offer experience that might encourage continued service in those areas.

2. A loan forgiveness program phased over a period of years for service in underserved areas should be implemented.

3. A study and evaluation of advertising and recruitment efforts by clinics should be undertaken to determine if a more aggressive approach to attracting physicians is possible.

4. Surveys should be conducted of those now serving or who have served in underserved areas to determine what attracts them to or detracts them from such service.

Issues of Concern

Liability of other physicians in the community who interact on referral or transfer of patients of pilot physicians may be of concern.

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Consumer Affairs

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June 6, 2001

Members
Subcommittee of the Task Force on
Culturally and Linguistically Competent
Physicians and Dentists

This is to express the position of the Medical Board of California relative to proposals for a Physicians and Dentists from Mexico Pilot Program as presented in the May 1, 2001 version of AB 1045 (Firebaugh). The elements contained in the bill which outline the standards for qualification of Mexican physicians have been fully considered by the Board, which supports the positive expressions of the desire to provide healthcare to a portion of California's residents who lack access to that care. Unfortunately, the proposals embodied in the May 1, 2001 version of AB 1045 would fail to achieve the goals outlined and could, instead, create a system which contains differences and inequities of potentially greater concern than those it seeks to overcome.

In the May 1, 2001 version of AB 1045, the proposed eligibility to function as a physician would require that, if the applicant holds a license in Mexico then he or she would be required to:

1. Complete Steps 2 and 3 of the United States Medical Licensure Examination (USMLE) or an equivalent examination developed by the Medical Board of California; and
2. Complete a six-month residency in California.

In exchange, the applicant would be eligible for an assignment to a clinic in one of a number of specified counties for an additional six-month residency before being granted a "temporary and limited" license to:

1. Work only in the specified clinic; and
2. Only for a period not to exceed three years.

If implemented, the first barrier that would be expected is the administration of the national exam (USMLE) that is currently required for licensure. This exam is administered by the Federation of State Medical Boards (FSMB). Preliminary discussion with the FSMB indicates that it would not administer Steps 2 and 3 of the exam without a record of the candidate's successful completion of Step 1. This fact would result in the second clause of the provision being invoked; that the Medical Board of California will develop an "equivalent examination." Beyond the Board's opposition to the creation of a different exam for the purpose of qualifying physicians to practice medicine in California, the Board is not a body that has the expertise or resources to

develop a licensing exam of this nature. Therefore, from a practical standpoint, achievement of this directive would require funding and creation of a test development function prior to embarking on the actual preparation and administration of an exam. This is a critical point because it delays the realization of any benefits of the proposed legislation by a time frame that is counted in years.

Assuming resolution of the exam predicament, there are concerns regarding the suggested six-month residency requirement. Postgraduate training (residency) has always been a critical requirement of the licensure process because it is the component of the system of physician preparation where the practitioner's clinical skills are more fully developed and evaluated. Recent data from the American Medical Association reflects that 90 percent of licensed physicians have three or more years of postgraduate training and that there is no jurisdiction in the United States that requires less than one year. Additionally, each of these programs are required to be accredited by the Accreditation Council for Graduate Medical Education, a requirement that is not proposed in AB 1045.

If adopted, the proposal embodied in the May 1, 2001 version of AB 1045 would result in the issuance of a "temporary and limited" license to the practitioner. There is a logical inconsistency which arises at this point from the perspective of professional licensing. That is the question of how a physician is recognized and authorized with the full authority of the State to practice medicine, but is restricted by time and location from the full exercise of those rights. Again, from the perspective of professional licensure, if the holder of a license is fully qualified within that profession, then the State would have no reason to restrict the time and practice location in which that license is to be considered valid. Conversely, if there are reasons to restrict the manner in which that license is to be considered valid, can the State, in good faith, assert that the holder is fully certified to practice within that profession? If it is held that the practitioner is not fully certified, then the State has failed to provide protection to the patients who ultimately receive the physicians' services with expectation that they have been licensed consistent with standards applied to all other physicians in California.

Beyond these issues, there are a host of questions raised by the proposed license which need to be addressed more fully. These include whether a limited license, of the type proposed, would restrict the holder's access to hospital privileges, DEA certification, malpractice insurance and other privileges that are typical features of medical practice.

Notwithstanding the concerns for the proposal as addressed above, the Medical Board of California does support those efforts that would improve the alignment of healthcare providers with underserved populations in all areas where there is need. As the agency responsible for protection of the public through the proper licensing of physicians and surgeons, the Board recognizes that it can exercise this responsibility in a proactive fashion whereby it works to facilitate the entry and the unrestricted practice of physicians who are qualified.

To achieve this aim, the Board proposes that the parties interested in pursuing the entry of qualified physicians from Mexico work to determine the most expeditious means of recruiting those physicians and achieving their licensure. The Medical Board recognizes that this proposal will require significant involvement on the part of many parties. The Medical Board would propose, for its part, to establish a single point-of-entry at the Board for physicians from Mexico. Its commitment would be to expedite the evaluation of these applicants, coordinate with national organizations to facilitate the qualification and scheduling for examination, work with residency training program directors to facilitate placement in approved programs and further expedite the licensing of these physicians upon completion of their residency. Concurrently, it is anticipated that the Board's Division of Licensing would hold hearings to determine if there exists opportunities to further amend statute in a manner designed to remove any barriers to licensure that are not supported by professional licensure standards or by the public's interest.

Finally, an opportunity to enhance the entry of physicians from Mexico exists through increased coordination and cooperation with external parties which have a role in physician education and qualification. This includes working with California's medical schools to explore opportunities for developing dedicated postgraduate training programs and slots to accommodate eligible applicants in the numbers necessary to meet the State's needs, and in exploring the revitalization of the Fifth Pathway Program for the education of a new generation of physicians; working with the Educational Commission on Foreign Medical Graduates (ECFMG) to streamline the certification process for eligible candidates; facilitating discussions with the Liaison Council for Medical Education (LCME) to determine the potential for the certification of medical education in Mexico as approved in the same manner as that offered in U.S. and Canadian schools; and a variety of other entities that might be able to assist in the expeditious qualification of eligible physicians.

The Medical Board envisions that this broader approach to the goal of providing culturally and linguistically competent physicians will result in a more successful and more complete long-term outcome by expanding the pool of eligible practitioners facilitating their eligibility to practice medicine consistent with those standards established for all current physicians and surgeons and by enabling their retention to serve residents statewide for a longer duration of time than the existing proposal.

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7-09-01 Version

Additional Amendments to AB 1045

Based on extensive discussions with interested parties, CHHCA intends to draft the following amendments:

SEC.2 (d) **strike to pass the California licensure examination,** and ADD after ...to,

1.) pass National Dental Exams or an equivalent examination to be developed by the California Dental Board. This exam shall be given in the Spanish language. In addition, licensed Mexican dentists who have passed this exam shall also be required to undertake a 6-month externship program at their place of employment. This externship will be developed and monitored by a dental school in California to be selected by the California Dental Board. The California Dental School shall convene a work group consisting of representatives from the California Dental Association (CDA), California Hispanic Health Care Association (CHHCA) and representatives from the government of Mexico including university dental school programs The purpose of this work group shall be to recommend the structure and monitoring procedures for the externship program.

Sec.2. 853 (B) Satisfactorily completed a six-month residency in California.

ADD...
This residency program shall be under the auspices of the University of California. A work group shall be established consisting of the University of California, the California Medical Association (CMA), the California Hispanic Health Care Association (CHHCA), and representatives of the government of Mexico and Mexican medical schools.

(C) Prior to taking U.S. medical and dental exams, selected Mexican licensed physicians and dentists shall be enrolled in an orientation/training program in Mexico that will provide information on vital issues of importance to Mexican physicians and dentists that required for practicing medicine and dentistry in California. The State Department of Health Services (DHS) shall convene a bi-national work group consisting of representatives of the CMA, CDA, CHHCA, Mexican government, Mexican dental and medical schools to provide recommendations on the development and implementation of this training program.

(D) Upon satisfactorily completing the residency in section (B) the applicant shall receive a limited and temporary license to work in non-profit community health centers and shall also be required to participate in a six-month externship at their place of employment. This externship would be undertaken after participant has received temporary license and is able to practice medicine. The externship would be to insure that participant is complying with established standards for quality assurance of non-profit community health center and medical practice.

ADD...

SEC. 3. Section 854 is added to the Business and Professions Code to read:

854. (a) _____ International Medical Graduates (IMGs) will be selected to participate in a pilot program whereby they will be required to meet the following requirements :

(1) Passed the FLEX, and
(2) Satisfactorily complete a six-month residency

(b) The Medical Board of California shall purchase the most recent version of the FLEX for IMGs and conduct the exam for eligible applicants during the month of June 2001.

(c) IMGs eligible to participate in this program shall be allowed to not have practiced medicine any more than two years from the time they take and pass the FLEX. IMGs who have worked, as a licensed medical professional prior to taking the FLEX shall be allowed to not have practiced medicine for no more than four years.

(d) IMGs who pass the FLEX shall be required to participate and satisfactorily complete a six-month residency at a non-profit community health center and corresponding hospital. This residency program shall be developed by an advisory committee to the University of California comprised of representatives from the University of California medical programs, from organizations representing physicians of California and minority physicians including associations of IMGs.

(e) Upon satisfactorily passing the FLEX and completing the residency program, IMGs shall be selected by non-profit community health centers to work in non-profit community health centers for a period not to exceed three years.

(f) The temporary and limited license issued to IMGs under this program will allow them to practice medicine only in the non-profit community health centers whose service area include federally designated Health Professional Shortage Area (HPSA), Dental Professional Shortage Area (DPSA), Medically Underserved Area (MUA) and/or Medically Underserved Populations (MUP).

(g) This temporary and limited license shall be deemed to be a license in good standing pursuant to the provisions of this chapter for the purpose of participation and reimbursement in all federal, state and local health programs.

ADD...

(e) Non-profit community health centers that employ participant shall be responsible for insuring that participants are enrolled in local English language instruction programs and will attain English-language fluency at a specific literacy level to serve English-speaking patient population when necessary.

ADD...

Sec. 4. Section 855 is added to the Business and Professions Code to read:

855. (a) Criteria for issuing temporary medical and dental licenses under this section shall not be utilized at any time as the standard for issuing a license to practice medicine or dentistry in California on a permanent basis.

BILL NUMBER: AB 1045 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY MAY 1, 2001

INTRODUCED BY Assembly Member Firebaugh

FEBRUARY 23, 2001

An act to ~~amend~~ *repeal and add* Section 853 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1045, as amended, Firebaugh. Healing arts: practice.

Existing law provides for a Task Force on Culturally and Linguistically Competent Physicians and Dentists in the Department of Consumer Affairs. Pursuant to existing law there is a subcommittee within the task force to examine the feasibility of a pilot program allowing Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in medically under-serviced areas. Existing law requires the subcommittee to report to the task force by March 1, 2001, and requires the report to be forwarded to the Legislature by April 1, 2001, with any additional comments.

This bill would ~~require the report's recommendations to be incorporated into the relevant statutory provisions by the enactment a statute~~ *remove provisions for the subcommittee and create the Licensed Doctors and Dentists from Mexico Pilot Program, setting forth provisions related to eligibility, licensing, location, hiring, and employment benefits and salary. The bill would also provide for an evaluation of the program, and for funding of the program costs by philanthropic entities* .

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes* . State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

~~SECTION 1. Section 853 of the Business and Professions~~

SECTION 1. Section 853 of the Business and Professions Code is repealed.

~~853. (a) A subcommittee of the task force established in Section 852 is hereby created to examine the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas.~~

~~(b) The subcommittee shall consist of the following members:~~

~~(1) The State Director of Health Services, who shall serve as the chair.~~

~~(2) The Executive Director of the Medical Board of California.~~

~~(3) The Executive Director of the Dental Board of California.~~

~~(4) The Director of the Office of Statewide Health Planning and Development.~~

~~(c) Additional subcommittee members shall be appointed by the State Director of Health Services, including the following:~~
~~(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.~~
~~(2) A representative of a nonprofit clinic association that advocates on behalf of members of language and ethnic minority groups and provides health services to a patient population that meets the following characteristics:~~
~~(A) Over 77 percent of patients are members of ethnic groups.~~
~~(B) Over 92 percent of patients have incomes less than 200 percent of the poverty level.~~
~~(C) Over 62 percent of patients do not speak English as their primary language.~~
~~(d) The subcommittee shall report to the task force by March 1, 2001, and the task force shall forward the report, with any additional comments, to the Legislature by April 1, 2001.~~
~~(e) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.~~

SEC. 2. Section 853 is added to the Business and Professions Code, to read:

853. (a) The Licensed ~~Doctors~~ Physicians and Dentists from Mexico Pilot Program is hereby created. This program shall allow up to 70 licensed ~~doctors~~ physicians and 50 licensed dentists from Mexico to practice medicine in California on a temporary basis, not to exceed three years.

(b) The Medical Board of California and the Dental Board of California shall issue temporary licenses to practice medicine to licensed Mexican ~~doctors~~ physicians and dentists, within the limits set forth in subdivision (a), who satisfactorily pass the specific requirements contained in this chapter.

(c) ~~Doctors~~ physicians from Mexico eligible to participate in this program shall:

(1) Be licensed and certified in their medical specialty in Mexico.

(2) Have completed the following requirements:

(A) Passed the second and third parts of the United States Medical Licensing Examination (USMLE), the National Boards, or an equivalent examination developed by the Medical Board of California.

(B) Satisfactorily completed a six-month residency in California.

(d) Dentists from Mexico eligible to participate in the program shall be required to be licensed in Mexico and to ~~pass the California licensure examination~~ (delete). Preference shall be given to graduates from Mexican dental schools who have applied to the Dental Board of California for reciprocity under Chapter 792 of the Statutes of 1998, which allows a foreign dental school to apply for academic reciprocity and provides that, if granted, its graduates need not complete two years of accredited studies prior to taking the dental licensure examination, commencing January 1, 2003.

(f) ~~(e)~~ ~~Doctors~~ physicians and dentists from Mexico having met the applicable requirements set forth in subdivisions (c) and (d) shall be placed in a pool of candidates who are eligible to be recruited for employment by nonprofit community health centers in California located in the Counties of Ventura, Los Angeles, San Bernardino, Imperial, Monterey, Orange, San Benito, Sacramento, Santa Cruz, Yuba, Colusa, Glenn, Sutter, Kern, Tulare, Fresno, Stanislaus, San Luis Obispo, and San Diego.

(g) ~~(f)~~ Nonprofit community health centers in the counties listed in subdivision (e) shall apply to the Medical Board of California and the Dental Board of California to hire eligible applicants who will

then be required to complete a six-month residency that includes working in the nonprofit community center and corresponding local hospital. Upon satisfactory completion of this residency, and upon payment of the required fees, the Medical Board of California and the Dental Board of California shall issue a temporary and limited license to practice medicine or dentistry in California for a period of three years from the date of issuance. A licensee shall practice only in the nonprofit community health center that offered him or her employment and the corresponding local hospital. This temporary and limited license shall be deemed to be a license in good standing pursuant to the provisions of this chapter for the purpose of participation and reimbursement in all federal, state, and local health programs.

(h) ~~(g)~~ The temporary license shall terminate upon notice by certified mail, return receipt requested, to the licensee's address of record, if, in the Medical Board of California or Dental Board of California's sole discretion, it has determined that either:

(1) The license was issued by mistake.

(2) A complaint has been received by either board against the licensee that warrants terminating the license pending an investigation and resolution of the complaint.

(i) ~~(h)~~ All applicable employment benefits, salary, and policies provided by nonprofit community health centers to their current employees shall be provided to medical practitioners from Mexico participating in this pilot program. This shall include nonprofit community health centers providing malpractice insurance coverage.

(j) ~~(i)~~ Beginning 12 months after this pilot program has commenced, an evaluation of the program shall be undertaken with funds provided from philanthropic foundations. The evaluation shall be conducted jointly by one medical ~~school~~ AND ONE DENTAL in California and the National University of Mexico (UNAM). This evaluation shall include, but not be limited to, the following issues and concerns:

(1) Quality of care provided by doctors and dentists licensed under this pilot program.

(2) Adaptability of these licensed practitioners to California medical and dental standards.

(3) Impact on working and administrative environment in nonprofit community health centers and impact on interpersonal relations with medical licensed counterparts in health centers.

(4) Response and approval by patients.

(5) Impact on cultural and linguistic services.

(6) Increases in medical encounters provided by participating practitioners to limited English-speaking patient populations and increases in the number of limited English-speaking patients seeking health care services from nonprofit community health centers.

(7) Recommendations on whether the program should be continued, expanded, altered, or terminated.

(k) ~~(j)~~ Costs for administering this pilot program shall be secured from philanthropic entities. ~~code is amended to read:~~

~~853. (a) A subcommittee of the task force established in Section 852 is hereby created to examine the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas.~~

~~(b) The subcommittee shall consist of the following members:~~

~~(1) The State Director of Health Services, who shall serve as the chair.~~

~~(2) The Executive Director of the Medical Board of California.~~

~~(3) The Executive Director of the Dental Board of California.~~

~~(4) The Director of the Office of Statewide Health Planning and Development.~~

~~(c) Additional subcommittee members shall be appointed by the State Director of Health Services, including the following:~~

~~(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.~~

~~(2) A representative of a nonprofit clinic association that advocates on behalf of members of language and ethnic minority groups and provides health services to a patient population that meets the following characteristics:~~

~~(A) Over 77 percent of patients are members of ethnic groups.~~

~~(B) Over 92 percent of patients have incomes less than 200 percent of the poverty level.~~

~~(C) Over 62 percent of patients do not speak English as their primary language.~~

~~(d) The subcommittee shall report to the task force by March 1, 2001, and the task force shall forward the report, with any additional comments, to the Legislature by April 1, 2001. The report's recommendations shall be incorporated into this chapter by the enactment of a statute.~~

~~(e) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.~~

Task Force on Culturally and Linguistically Competent Physicians and Dentists, Subcommittee on the Pilot Program---- Pursuant to AB 2394 (Firebaugh); Revised May, 2001 as AB 1045

Comments of Hector Flores, MD and Aliza Lifshitz, MD
June 14, 2001

Note: Our comments are based on our participation on the Task Force as practicing physicians who provide services to members of language and ethnic minority groups, and as a members of the California Latino Medical Association (CaLMA).

I. Background Issues

It is well documented and understood that safety net providers are a significant resource for medically underserved communities, especially for the medically indigent. It is also well understood that many safety net providers have had difficulty recruiting (and retaining) culturally and linguistically competent clinicians. Further, it is well understood that the current rate of health care workforce production in the United States (especially those who may be considered to be culturally competent), in both the short-term and long-term, is not likely to meet the needs of critical health professions shortage areas. Thus, there is a compelling need to explore a short-term solution to this challenge. The Pilot Program attempts to address this issue.

However, there are some important considerations:

1. The pilot program would add to an existing "brain drain" on the exporting country, in this case, Mexico, which is a country that has not developed a complete infrastructure to support and retain its physician workforce. As a result, there are thousands of physicians from Mexico already in the United States today who are busy seeking licensure for practice in America. Many of these individuals are U.S. citizens or legal residents who have chosen to complete their medical studies abroad (often referred to as United States International Medical Graduates, or "U.S. IMGs").

2. The pilot program, as revised, excludes physicians and dentists from other Latin American countries, and for that matter, professionals from other nations. This may be challenged under the non-discrimination provisions of Title VI of the Civil Rights Act of 1964.

3. The pilot program proposes a partial waiver of California licensure guidelines by requiring candidates to pass USMLE Part II and Part III only. The rationale is that Part I is a basic science-oriented examination that has little relevance to actual practice and represents knowledge that practicing physicians rarely, if ever, use, whereas Part II and Part III are more clinically oriented and therefore represent knowledge relevant to good quality of care. The difficulty here is that this type of waiver sets a precedent that time-tested patient protection measures, i.e., USMLE Part I, II, and III can be bypassed for a special project. If, indeed, Part I is irrelevant then

perhaps the best strategy is to reform U.S. medical licensure guidelines and do away with USMLE Part I altogether, since Part I is known to be a major cause of attrition in U.S. medical schools.

4. The pilot project is unfair to the physicians and dentists recruited from Mexico because of its limitations: a) uncertain immigration status that is time-limited, after which the clinician is forced to return to Mexico; b) limitations on practice location options and potentially a ceiling on compensation; and c) a personal price paid by health professionals who will leave their families behind in Mexico and/or who will develop a relationship (and perhaps marry and have U.S. citizen children) while working in California. This differential treatment may even be challenged based on the non-discrimination clause of the Civil Rights Act of 1964.

5. This type of project detracts from the efforts of the last 35 years to ensure equal opportunity in health professions education for America's disadvantaged and ethnic minority communities. There is a need to ensure self-sufficiency in workforce development in United States schools and not depend on importing physicians from other countries. This type of pilot program may detract from efforts to hold U.S. schools accountable for ensuring that under-represented minorities and disadvantaged students are given a chance to enjoy academic success and to compete effectively for health professions training opportunities.

II. CaLMA Position on the proposed Pilot Program

The CaLMA is concerned about the issues described above. The position of the CaLMA is to **oppose** the proposed Pilot Program as written. Instead, CaLMA offers the following alternatives:

1. The Subcommittee should explore mechanisms to integrate U.S. IMGs into this pilot program. Many of these individuals are culturally, linguistically, and experientially sensitive to needs of California's most vulnerable communities. United States IMGs also eliminate the uncertain immigration status concerns because they are already citizens or permanent residents.

2. Rather than attempting to bypass the California licensure guidelines, the Pilot Program should develop guidelines to achieve academic reciprocity for certain Mexican medical schools in the same manner that such reciprocity exists for certain Canadian and European medical schools.

3. The program should maintain English language requirements, since the clinician will need to communicate with non-Spanish speaking colleagues and consultants.

4. Remove the "guest worker" status of the Mexican physicians and dentists in this pilot program and enact provisions that allow them to stay permanently.

5. Rather than limiting the practice opportunities to a few clinics, candidates should also be given the opportunity to choose from the hundreds of free and community clinics throughout the state of California which are serving equally-needy communities.

6. Explore other training options such as Physician Assistant programs for U.S. IMGs.

III. Other Short-term and Medium-term Options

1. Re-institute the fifth pathway programs for IMGs that existed in the 1970s and 1980s with new criteria for selection of candidates who have an orientation to practice in medically underserved areas. These programs can be integrated with the recommendations to be submitted to the California Medical Board and the California Dental Board by the Task Force in 2003.

2. Re-invigorate the California Code of Regulations Section 1324, Title 16 program that allowed IMGs to receive training and licensure under the auspices of accredited teaching hospitals and graduate medical education programs.

3. Expand and augment existing graduate medical education (e.g., residency programs for physicians, nurse practitioners, and physician assistants) programs recognized by the Office of Statewide Health Planning and Development (OSHPD) as exemplary in their efforts to recruit, train, and retain graduates in medically-underserved areas.

4. Augment existing scholarship and financial assistance programs for economically disadvantaged students interested in the health professions. These programs could also be offered to US IMGs for USMLE preparation or Physician Assistant training.

5. Expand the successful state of California loan repayment programs that allow health professionals to have a percentage of their school loans repaid for every year they practice in a medically underserved area.

6. Expand the California Shortage Area Medical Matching Program (Cal SAMMP) that assists the recruitment efforts of health centers and medical providers serving medically-needy areas.

7. Collaborate with the "Welcome Home" program for US citizen/resident graduates of international health professions training schools.

IV. Long-Term

1. Develop a comprehensive disadvantaged and minority student Applicant Pool development, recruitment, retention, graduation, and placement project for the state of California that coordinates the efforts of schools and training institutions along the educational "pipeline". The OSHPD has exemplary programs and could provide the oversight for this type of project.

2. Develop a strategy for academic enrichment and retention of the thousands of minority college students who each year indicate an interest in a medical career. Each year there are approximately 3,000 entering pre-medical college students whose ethnic minority group is known to be under-represented in the health professions. By the time they graduate, only approximately 500 apply to medical school. Of these, only half are accepted to medical school. Most of these once-aspiring physicians are lost to careers other than the health professions. Part of this strategy would be to expand the successful state of California Minority Medical Education and Training (MINMET) program that links pre-baccalaureate and post-baccalaureate enrichment programs with health professions training schools. This type of project could be led by OSHPD in conjunction with the University of California Medical Student Diversity Task Force (which includes members of all the allopathic public and private medical schools) and the two osteopathic medical schools in California.

3. Health professions development programs should not be limited to the medical and dental professions, as there are acute shortages in nursing and allied health professions and not all students are interested in a medical or dental career.

4. Develop K-12, technical school, community college, four-year university, and health professions school collaborative efforts to create a seamless transition for students interested in the health professions. This includes establishing and standardizing the functions of career counseling offices, and standardizing training for career counselors and "key informant" faculty trusted by students and their families.

5. Establish a health professions education reform strategy (e.g., at the medical, dental, nursing school level) which ensures that all students, regardless of ethnic background or nationality, develop the competencies necessary for practice in a culturally and linguistically diverse society.

6. Ensure that the Task Force completes its report by 2003 making recommendations for standards of cultural and linguistic competence and how these would be reflected in Continuing Medical Education and licensing requirements.

July 5, 2001

Diana M. Bontá, RN, Dr.P.H.,Director,
Department of Health Services
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320

Dear Dr. Bontá: **Sent via facsimile, original mailed**

Thank you for having staff prepare the Element Matrix and for the opportunity to comment on it. I have noted the support of the Latino Coalition for a Healthy California (LCHC) and this letter represents the view of our organization and a further clarification of our position on this matter.

First, I would like to assure you and others that the LCHC has long held the position that access to health care is a right, that should be accessible for all, regardless of their ability to pay. The LCHC continues to advocate that such access includes services that are provided in a culturally and linguistically competent manner. We strongly oppose any attempt to lower the licensing standards for physicians and dentists providing health services to the indigent. Therefore, we recommend:

- That a pilot project be established to provide incentives for physicians/dentists to provide health care services in medically underserved areas (not limited to 12 in original proposal).
- All physician/dentist participants in the pilot project meet all existing California/US residency training and licensing standards for physicians and dentists, leading to permanent license to practice in California. At a minimum, the same licensing requirements of International Medical Graduates.
- All participants be required to serve in an underserved area for a specified time as a condition of being allowed to participate in the pilot project.
- All participants should be able to communicate in both English and Spanish to ensure that their communications with providers and others accurately convey clinical and other information pertinent to the care of patients.

These positions are consistent with three of the four proposals submitted by the Subcommittee members on physicians. Therefore, we would like to recommend that the following options be combined and pursued to provide the broadest opportunity to address the issue of access to health care in underserved areas:

- Options listed in the CaLMA proposal under section II and III and IV.
- Options listed in the CMA proposal, numbers 1-4 under Short Term and Long Term.

LATINO COALITION FOR A HEALTHY CALIFORNIA
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- Options listed on page 2, last paragraph through last paragraph page 3 of the Medical Board of California proposal.
- Options proposed by the California Dental Association.

The major positive aspects of all the proposals should be combined into one proposal. In addition, it is recommended all of the proposal authors be requested to complete the additional information, to be submitted prior to, and included in the August 15 report to the legislature:

- The commitment each representative and their organizations are willing to make to the project,
- The estimated timeframes required to meet the commitments and recommended actions,
- The accountable persons and/or organizations for each aspect of the proposal.
- There may be organizations outside of purview of the proposal authors that need to approve various aspects of the proposals, they need to be identified as well as a recommendation on the lead agency, Subcommittee member or individuals responsible for securing that approval.

This will provide the legislature and others with a better understanding of the level of commitment required, the time it will take to complete the tasks outlined and the parties and/or organizations that would have to involved to accomplish the projects proposed.

The Subcommittee should be allowed to continue its work beyond the submission of the report to the legislature. We should be allowed more flexibility and opportunity to collaborate as we continue our work. The Subcommittee structure has been quite confining. Yet, in spite of the restrictions, I believe we made progress at our last meeting. Several concessions have been made by all of the organizations represented on the Subcommittee to present options towards a pilot project that would provide a cadre of qualified, culturally and linguistically competent physicians and dentists to medically underserved areas. However, no one proposal addresses all of the issues. It will take a combination of each of the proposals and further concessions to reach a consensus for a more cohesive overall set of recommendations. I remain optimistic that we can accomplish this goal.

Thank you again for the opportunity to comment.

Sincerely,

Lia Margolis
President and CEO

LM:jrs

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DRAFT LETTER TO DR. BONTÁ

July 5, 2001

Diana M. Bontá, RN, Dr. PH
Director
Department of Health Services
PO Box 942732
Sacramento, CA 94234-7320

RE: AB 2394: Subcommittee of the Task Force on Culturally and Linguistically Competent Physicians and Dentists

Dr. Bontá,

Your staff did a wonderful job in compiling the five proposals into a document that is clear and easy to read as we attempt to draft a proposal on the feasibility of bringing physicians and dentists trained outside the United States. Both a short- and a long-term "strategy" is evident from a review of the matrix and both would seem to be linked to establishing academic reciprocity with those medical and dental schools.

A. In the short-term, medical/dental graduates from schools in Mexico and the Caribbean countries who are already residing in the US would be included in the pilot project, thus increasing the pool of eligible candidates (proposed by the California Hispanic Health Care Association and California Latino Medical Association).

    1. A requirement that these eligible candidates must have been practicing medicine or completed their training within the last two years could be established to assure that practice skills are current, as this may be required by licensing and by accrediting bodies at the hospital level.

    2. Testing the candidates by using Parts II and III of the USMLE can be readily achieved in the short-term; I

am not so sure that Part I has all the relevance that we are lead to believe. Specialty board certification does not use basic science as a separate test; rather it is incorporated into clinical questions that test the understanding of this material, which may be more relevant.

3. Drawing candidates trained in schools that have been accredited using the US medical school's criteria can be achieved in the short-term. Discussions with officials in Mexico have indicated that as many as one fourth of the medical schools in Mexico have been accredited using this criteria. The Universidad Nacional Autonoma de Mexico (UNAM) is one of these and could be a source for the first group of physicians and dentists. The quality of the medical school and residency curriculum could be reviewed by the University of California to establish benchmarks for reciprocity. The reciprocity would then be used as a factor in determining how long of a residency training program would be required to satisfy requirements for licensing. I believe that the critical factor is in the reciprocity, as this seems to be where the parallels were drawn for physicians trained in Canadian schools. A one-year residency as described in the California Hispanic Health Care Association's proposal would seem sufficient. There are some features of reciprocity for dentistry with the program outlined by the California Dental Association.

4. Assessing English language proficiency is also short-term, as physicians/dentists at the UNAM have indicated that candidates sought out for the pilot program would have to be proficient in English if they were to be successful in caring for their patients in California. Taking a medical examination in English is not the same as testing for language proficiency; the medical examination would be conducted in Spanish, while the ability to communicate in English can be tested differently.

5. A temporary three-year license could be achieved if the short-term initiatives can be achieved. Beyond three years would require a separate process that each

person outside of the pilot program could pursue. Mexican officials have indicated that they would not be supportive of any effort that results in a loss of physicians/dentists to the United States.

6. In the short-term, physicians/dentists would be placed only in community health centers located in 18 specified counties.

B. Long-term solutions would need to "expand" on the initial efforts identified for the short-term.

1. Integrating more US international medical graduates (IMG) would be a consideration for creating a pool of physicians/dentists with a more permanent license in California. Over time, this may become the pool of physicians/dentists who would be serving in the health professions shortage areas, being drawn to those locations in pursuit of scholarship/loan repayment/tax break/housing opportunities provided by the State of California.

2. Training programs would have to be created to assist those candidates who have been out of school or not practicing medicine/dentistry for over two years, to prepare for licensing exams. The "Welcome Home Program" prepares a small number of physicians for work in California and this could be expanded to include more candidates. In addition, residency programs would need to increase the number of positions available to place candidates to fulfill licensing requirements.

I am not sure how the SPEX is given and perhaps this discussion could be useful in describing its role for the short- or long-term.

I hope that our discussions will assist our subcommittee's work in developing a viable program that can serve the needs of families served by the community health centers located in health professions shortage areas. Short- and long-term strategies are requisite for any plan to work; neither one can exclude the other.

Respectfully submitted,

Maximiliano Cuevas, MD, FACOG
Chief Executive Officer
Member, Subcommittee of the Task Force on Culturally and Linguistically Competent Physicians and Dentists

Assembly Bill 2394 (Firebaugh)
Chapter 802, Statutes of 2000

Assembly Bill No. 2394

CHAPTER 802

An act to add Sections 852 and 853 to the Business and Professions Code, relating to the healing arts.

[Approved by Governor September 28, 2000. Filed with Secretary of State September 28, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2394, Firebaugh. Healing arts: cultural and linguistic competency.

Existing law includes provisions generally applying to the licensure and certification of all healing arts practitioners.

This bill would establish the Task Force on Culturally and Linguistically Competent Physicians and Dentists, chaired by the State Director of Health Services and the Director of Consumer Affairs, and would specify the task force's duties, including, among other things, developing recommendations for a continuing education program that includes language proficiency standards of a foreign language to meet linguistic competency, and identifying the key cultural elements necessary to meet cultural competency, and reporting to the Legislature and to licensing boards within 2 years of its establishment.

This bill would establish a subcommittee of the task force and would require the subcommittee to submit a report to the task force by March 1, 2001, to be forwarded to the Legislature with any additional comments by April 1, 2001, on the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved communities. This bill would specify that the Medical Board of California and the Dental Board of California shall pay the state administrative costs associated with the task force and its subcommittee.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Thirty-three and eight-tenths percent of Medi-Cal recipients in 1998 spoke a foreign language; Spanish was the number one foreign language spoken.

(b) National medical journals and associations have acknowledged the importance of having medical providers be

cultural and linguistically competent to serve culturally diverse patients.

(c) The Journal of the American Medical Association, 1999, ''Race, Gender, and Patient-Physician Relationship'' Volume 282 #6, stated that ''Without cultural competence, a physician may (1) unintentionally incorporate racial biases into his or her interpretations of patients' symptoms, predications of patients' behaviors, and medical decision making; (2) lack understanding of patients' ethnic and cultural disease models and attributions of symptoms; (3) be unaware of or have expectations of the visit that differ from patients' expectations.''

(d) In 1995, 1,641 underrepresented minorities applied to California medical schools and 231 were admitted; in 1998, this number declined to 1,223 applications and 184 admissions.

(e) Only 0.8 percent of medical schools in the United States require a separate course on multicultural medicine; even fewer require any classes in cultural and linguistic competency.

(f) The lack of cultural and linguistic competency among medical providers may be dangerous to the health of certain patients.

SEC. 2. Section 852 is added to the Business and Professions Code, to read:

852. (a) The Task Force on Culturally and Linguistically Competent Physicians and Dentists is hereby created and shall consist of the following members:

(1) The State Director of Health Services and the Director of Consumer Affairs, who shall serve as cochairs of the task force.

(2) The Executive Director of the Medical Board of California.

(3) The Executive Director of the Dental Board of California.

(4) One member appointed by the Senate Committee on Rules.

(5) One member appointed by the Speaker of the Assembly.

(b) Additional task force members shall be appointed by the Director of Consumer Affairs, in consultation with the State Director of Health Services, as follows:

(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.

(2) California licensed physicians and dentists that provide health services to members of language and ethnic minority groups.

(3) Representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups.

(4) Representatives of entities that offer continuing education for physicians and dentists.

(5) Representatives of California's medical and dental schools.

(6) Individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.

(c) The duties of the task force shall include the following:

(1) Developing recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency.

(2) Identifying the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices.

(3) Assessing the need for voluntary certification standards and examinations for cultural and linguistic competency.

(d) The task force shall hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups to determine their needs and preferences for having culturally competent medical providers. These hearings and meetings shall be convened in communities that have large populations of language and ethnic minority groups.

(e) The task force shall report its findings to the Legislature and appropriate licensing boards within two years after creation of the task force.

(f) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.

(g) Nothing in this section shall be construed to require mandatory continuing education of physicians and dentists.

SEC. 3. Section 853 is added to the Business and Professions Code, to read:

853. (a) A subcommittee of the task force established in Section 852 is hereby created to examine the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas.

(b) The subcommittee shall consist of the following members:

(1) The State Director of Health Services, who shall serve as the chair.

(2) The Executive Director of the Medical Board of California.

(3) The Executive Director of the Dental Board of California.

(4) The Director of the Office of Statewide Health Planning and Development.

(c) Additional subcommittee members shall be appointed by the State Director of Health Services, including the following:

(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.

(2) A representative of a nonprofit clinic association that advocates on behalf of members of language and ethnic minority groups and provides health services to a patient population that meets the following characteristics:

(A) Over 77 percent of patients are members of ethnic groups.

(B) Over 92 percent of patients have incomes less than 200 percent of the poverty level.

(C) Over 62 percent of patients do not speak English as their primary language.

(d) The subcommittee shall report to the task force by March 1, 2001, and the task force shall forward the report, with any additional comments, to the Legislature by April 1, 2001.

(e) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.

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July 10, 2001 SUBCOMMITTEE MEETING MINUTES

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

Draft Meeting Minutes
Subcommittee of the Task Force on Culturally and linguistically Competent Physicians and Dentists
July 10, 2001
Department of Consumer Affairs Hearing Room
400 R Street, Suite 1030, Sacramento, CA

Subcommittee Members Present:
Diana M. Bontá, R.N., Dr.P.H., Director, Department of Health Services, Chair
Anmol Singh Mahal, M.D., California Medical Association
Jack Broussard, D.D.S., California Dental Association
Arnold Torres, Executive Director, California Hispanic Health Care Association
Lia Margolis, Latino Coalition for a Healthy California
Ron Joseph, Executive Director, Medical Board of California
Georgetta Coleman, Executive Director, Dental Board of California

Subcommittee Members Not Present:
David Carlislie M.D., Ph.D., Director, Office of Statewide Health Planning and Development (OSHPD)
Alisa Lifshitz, M.D., California Hispanic-American Association
Hector Flores, M.D., Department of Family Practice, Memorial Medical Center, Los Angeles
Anil Chawla, M.D., Clinicas del Camino Real
Maximiliano Cuevas, M.D., Executive Director, Clinicas de Salud del Valle de Salinas

Task Force Members Who are Not Subcommittee Members Present
Albert Gaw, M.D., Medical Director, Mental Health Rehabilitation Facility
Newton Gordon, D.D.S., University of California, San Francisco School of Dentistry
Miya Iwataki
Felipe Santana, Ph.D.
Doreena Wong, National Health Law Program

Staff Members Present:
Kristy Wiese, Assistant Deputy Director, Department of Consumer Affairs
Anita Scuri, Legal Counsel, Department of Consumer Affairs,
Norman Hertz, Ph.D., Office of Examination Resources, Department of Consumer Affairs
Jean Iacino, Special Assistant to the Director, Department of Health Services
Jack Dillenberg, M.P.H., D.D.S., Associate Director for Public Health Programs, Department of Health Services
Janet Smith, Senior Staff Council, Department of Health Services
Greg Franklin, Chief, Office of Multicultural Health, Department of Health Services

Audience:
Sign in sheet attached

Agenda Item #1: Call to Order and Establishment of a Quorum

Director Bontá, Chairperson, called the meeting to order at 10:20 a.m. Since there were only 6 of the 12 Subcommittee members present when the meeting convened, a quorum could not be established. Subsequently, Ms. Coleman arrived, establishing a quorum.

Director Bontá welcomed everyone to the meeting, and announced that the Task Force meeting would commence at 1:30 p.m. She also thanked all the Subcommittee members for their attendance and asked that they introduce themselves.

Agenda Item #2: Review and Approval of the June 19, 2001, Subcommittee Meeting Minutes

Director Bontá requested the members to review the minutes but reminded everyone that the minutes could not be adopted due to the lack of a quorum.

Agenda Item #3: Foreign Licensure Equivalency

Director Bontá welcomed Norman Hertz, Ph.D., Chief of the Office of Examination Resources, Department of Consumer Affairs. Dr. Hertz was invited to present to the members information regarding the licensure equivalency and examination process.

Dr. Hertz began his presentation by discussing the four major components that must be evaluated as part of a licensure examination:

1. Education
2. Experience
3. Examination
4. Standards of Practice or Care

Dr. Hertz discussed each element as it relates to licensure. Each element carries equal weight in the evaluation. The ***education*** that one receives prepares one for the ***experience*** one attains during an internship and that prepares one to take the ***examination*** and the final part is the ***standard of practice of care.***

Frequently Asked Questions when Determining Licensure Equivalency:

- Are the courses of study equivalent? For example, does one curriculum require a chemistry class with a laboratory component while the curriculum being compared requires a chemistry class but has no laboratory component?

- Are the institutions that provide the diploma or degree regionally or nationally accredited? Are the education programs accredited within the university?

- Is the education of the instructors equivalent? Do the instructors have a license or credential?

- Is the number of hours for education and training equal among certified supervisors?

- During the internship, what types of clients are served? Are they only patients that a person in training would see or do they represent the population as a whole? Are they typical situations that a provider would see in the general public or are they examples of situations that only a person in training would see?

- Is the supervisor's performance evaluated? Is there a means to remove people from training that do not meet requirements to insure that interns' training will be successful? Are the internships subject to third-party approval?

- Is examination for licensure equivalent? Do both examinations measure the same skills? Are they standardized? Do they meet the standards of educational and psychological testing?

The security of examinations must also be evaluated. If it's violated, the exam has no relevance.

The purpose of licensing exams is to measure job knowledge. Licensing is the highest level of examination.

Standards of practice must represent the level of competence expected of the practitioner. Minimum competence standards combine education and experience. Evaluating the standards of practice is key to consumer protection. We can evaluate licensing equivalency through the use of an occupational analysis. An occupational analysis can be used to determine the competency that is needed to practice, examination content, and standards for care. Without an occupational analysis we cannot assume that the four elements are equivalent and that the examination is valid.

Dr. Hertz concluded his presentation.

Director Bontá asked about the required timing of passing the three parts of the United States Medical Licensing Examination (USMLE) in order to be licensed as a physician in California.

Mr. Joseph stated that typically Parts I and II of the USMLE are given relatively close in time. Most schools would require that a student complete Parts I and II prior to

graduation. However, there is no legal standard specifying the timing of the various parts of the exam.

Ms. Margolis asked if an occupational analysis is an alternative to evaluating the equivalency of licensure programs and if an occupational analysis has been done for medical and dental professionals in Mexico.

Dr. Hertz answered that an occupational analysis can be used to set curricula, licensing standards, and standards of care. To his knowledge an occupational analysis has not been done with Mexican doctors and dentists. An occupational analysis usually takes one to two years.

Dr. Hertz also explained that the occupational analysis is done when requested by a Department of Consumer Affairs Board, Bureau, or Program. The occupational analysis can also be contracted out to a private party.

Mr. Joseph stated the organizations that develop and administer the national medical and dental licensing examinations perform ongoing occupational analyses.

Mr. Torres noted that if a medical student fails Part I of the USMLE, he/she is not allowed to take Part II of the examination. The USMLE requires a significant knowledge of English, which creates a barrier for doctors educated in Mexico.

Mr. Torres stated there is a national level licensing examination in Mexico but no attempt has been made to determine its equivalency to the USMLE.

Dr. Hertz indicated that an occupational analysis would be required as part of establishing such equivalency.

Agenda Item #4: Proposal and Discussion of Alternative Pilot Projects

Ms. Iacino provided an overview of the matrix of possible pilot project elements. The matrix has been updated to reflect changes and comments from the Subcommittee members. An “X” in an element box indicates that the corresponding organization has specifically agreed to inclusion of that element.

Director Bontá asked for any changes from Subcommittee members to the matrix in this discussion.

Mr. Torres added that the California Hispanic Health Care Association (CHHCA) proposal has been revised to include international medical graduates. The change was presented in writing and the CHHCA proposal is now identical to the proposal submitted by Dr. Cuevas.

Subcommittee members discussed whether the elements that Subcommittee members agree upon should be presented as a pilot program or if the areas of disagreement should be highlighted.

Although many members agreed on a number of the proposed elements, there was significant disagreement upon the time frame for implementing a pilot project, the temporary or permanent nature of licensure, education requirements for licensure, placement of doctors and dentists who participate in a pilot project, and how to determine cultural and linguistic competency.

Director Bontá was called away from the meeting and asked Ms. Margolis to chair the remainder of the meeting.

Mr. Torres that the Mexican Consul was present and would answer questions from the Subcommittee.

Mr. Solozano, Mexian Consul General, introduced himself and stated the Mexican government is very interested in the proposal to allow doctors and dentists from Mexico to practice here. They have not sent a letter of support but could very easily do so. Mr. Solozano stated he was representing the Mexican Health Ministry.

Ms. Margolis asked for clarification from legal counsel as to exactly what is necessary for the Subcommittee to meet its mandate. If the Subcommittee formally disbanded, how would any future action be recognized? Are there alternatives for level of standing?

Anita Scuri, counsel for Department of Consumer Affairs, stated once the work of the Subcommittee is complete it may disband. After disbanding, Subcommittee members can still meet and discuss issues but the meeting and discussion would have no official standing.

Dr. Broussard spoke in favor of disbanding the Subcommittee, stating that the Subcommittee has come as far as it can with decisions and proposals.

Mr. Joseph agreed with Dr. Broussard and moved that the Subcommittee be disbanded and that they would present this decision this afternoon to the Task Force.

Mr. Torres moved to forward the matrix (revised to specifically state the five major areas of disagreement) and the supporting proposals as the Subcommittee's report to the Task Force, fulfilling the Subcommittee's task under Assembly Bill 2394, and disband. Dr. Broussard seconded the motion. Due to the absence of Director Bontá (whose presence was necessary to constitute a quorum), a vote on the motion was delayed until the Subcommittee could break for lunch and reconvene immediately prior to the full Task Force meeting scheduled at 1:30 p.m.

The meeting adjourned at 12:35 p.m.

Director Bontá reconvened the Subcommittee at 1:30 p.m., at which time a quorum was present and voted unanimously to forward the matrix proposal to the full Task Force for transmittal to the Legislature and to disband the Subcommittee.

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